

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390110	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/04/2023
NAME OF PROVIDER OR SUPPLIER: CONEMAUGH NEUROLOGY, PAIN & OUTPATIENT SURGERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1450 SCALP AVENUE Suite 2100 JOHNSTOWN, PA 15904		
STATE LICENSE NUMBER: 24521501				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0000	<p>INITIAL COMMENT</p> <p>This report is the result of a State licensure survey conducted on April 4, 2023, at Conemaugh Neurology, Pain and Outpatient Surgery Center. It was determined the facility was in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.</p>	S 0000		

(X6) DATE:



Certified End Page

CONEMAUGH NEUROLOGY, PAIN & OUTPATIENT SURGERY CENTER

STATE LICENSE NUMBER: 24521501

SURVEY EXIT DATE: 04/04/2023

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY